STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009427	A. BUILDING: _____ B. WING _____	C 09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOULON REHAB & HEALTH CARE CENTER	HIGHWAY 17 EAST P O BOX 209 TOULON, IL 61483

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Incident Report Investigation To Incident Of 7/3/2015/IL79780. Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

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S9999	Continued From page 2 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on record review and interview the facility failed to inform the Physician promptly of changes in resident condition, regarding a new onset of bruising around eyes, change in mental status and a decline in ambulation for one of three residents (R1) in a sample of three who were reviewed for physician notification. In addition, the facility failed to provide supervision for two of three residents, (R1, R2), reviewed for falls, in a sample of three. These failures resulted in R1 and R2 requiring transport to the local hospital, due to several falls sustaining lacerations to the head. R1 subsequently died due to head trauma and R2 required treatment to laceration of head (staples.) Findings Include:	S9999		

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The facility's Change in Condition Policy, dated 2003, documents: " Immediate Notification to the Medical Doctor: any symptom, sign or apparent discomfort that is: acute or sudden in onset, and a marked change (more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Under signs and symptoms, consciousness, altered, sudden change in level of consciousness or responsiveness (call MD/NP/PA) Medical Doctor, Nurse Practitioner, Physician Assistant. The facility's Neurological Checks Policy, dated 01/07 documents: " 10.) Signs of increased cranial pressure must be reported to the physician immediately. These signs are as follows: Diplopia, dizziness, nausea and vomiting, lethargy, headache, temperature elevation." Under signs and symptoms, weakness of, arm or leg, abrupt onset of noticeable change in strength or use. Weakness, general, Abrupt onset of general weakness with fever or other acute symptoms."

R1's Fall Risk Assessment dated 7/3/2015 documents a score of 20. R1 is a high risk for falls.

R1's incident report, dated 7/3/2015, documents that R1 fell and has a laceration to the back of R1's head. R1 was sent to the local emergency room for evaluation.

R1's Physician Documentation Form from a local hospital emergency room, dated 7/3/2015, states: "The patient fell from an upright position, while walking. Associated injuries: The patient sustained injury to the head. Wound repair of 3 CM (Centimeter) subcutaneous laceration to left occipital area."

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R1's CT (Computerized Tomography) to the head, dated 7/3/2015 documents, "No intracranial hemorrhage."

E4/LPN (Licensed Practical Nurse) documents, on 7/16/2015 at 1:00pm. "(R1) on floor lying on (R1)'s back, blood under (R1)'s head. Noted laceration on (R1)'s head where staples were removed. (R1) was sent to local hospital emergency room for evaluation and treatment."

R1's (MDS) Minimum Data Set, dated 7/8/2015, documents that R1's (BIMS) Brief Interview for Mental Status indicates R1 is severely impaired.

R1's care plan, dated 7/10/2015, documents "Observe for and educate on proper transfer technique and use of devices."

R1's care plan, dated 7/16/2015, documents to "Encourage R1 to minimize ambulation and wait for assistance."

R1's Resident Transfer Form dated 7/16/2015 at 12:15pm, documents that R1 fell to the floor and hit R1's head in the exact same spot that R1 had previously injured on 7/3/2015.

R1's CT examination of the head, dated 7/16/2015, documents left parietal superficial soft tissue swelling/ contusion/ hematoma.

R1's Physician Documentation Form, dated 7/16/2015, documents, "The patient sustained injury to the head. The patient has experienced similar episodes in the past, several times. Wound repair of 4CM subcutaneous laceration to left parietal area."

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S9999	Continued From page 5	S9999		

Incident report for R1 dated 8/13/2015 documents that R1 fell 8/7/2015 at 11:10am. R1's nurses notes, dated 8/7/2015 at 11:10am, document that R1 was noted on floor,with a "y" shaped laceration to the back of R1's head, where R1's old healing laceration was. R1 was not sent to the emergency room for evaluation of the laceration of R1's head.

Nurse's notes, dated 8/8/2015 at 11:00am, documented that R1 has bruising noted under R1's bilateral eyes. There is no verification that R1's physician was notified of R1's change of condition.

Nurse's notes, dated 8/12/2015 at 5:00am, documented that R1's gait was poor. R1 was weak and required two assist with all of R1's activities of daily living. There is no verification that the physician was notified of R1's change of condition.

Nurse's notes, dated 8/12/2015 at 8:00pm, documented that R1 had an increase in lethargy and decreased ambulation, and R1 needed two assist with tranfers. There is no verification that R1's physician was notified of change in R1's condition.

On 9/2/2015 at 10:40am, E4 (LPN) Licensed Practical Nurse stated, It was the morning after the incident, I came in and noticed bruises around (R1)'s eyes. I related the bruises to the fall from last night. I did not call doctor, but I faxed."

On 9/2/2015 at 9:42am, E10 (Primary Care Physician's Medical Assistant) stated, "If nursing homes fax anything over to our office we place them in each resident's file. There is no fax in (R1)'s file from 8/8/2015 concerning bruising

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S9999	Continued From page 6	S9999		

around (R1)'s eyes. If E9 (Medical doctor) would have known of (R1)'s bruising around (R1)'s eyes, E9 would have of sent (R1) in to be evaluated."

On 9/2/2015 at 1:15pm, E7/ LPN (Licensed Practical Nurse) stated, " I felt (R1) appeared weaker than usual, (R1) could not ambulate alone and needed more assistance.
E7 /(LPN) Licensed Practical Nurse, stated, "Usually (R1) walks better, (R1) acted like he was gonna fall, (R1) had a change in condition, I did not feel doctor needed to be involved."

On 9/2/2015 at 1:38pm, E2 (DON) Director of Nurses stated, "I do feel that (R1) being weaker and not being able to walk on his own, and increase lethargy is a change in condition, and doctor should have been made aware of changes, per policy." E2, DON stated, "(R1)'s bruises around both eyes I feel are related to (R1)'s falls, I did not see where (R1)'s physician was made aware of (R1)'s bruising around eyes."

On 9/2/2015 at 9:42am, E9 (Physician) stated, "I would expect to be called with any change in resident's condition."

On 9/2/2015 at 2:55pm, E6/RN (Registered Nurse) stated that R1 is normally able to walk independently. E6 also stated that R1 would not remember to use R1's call light. E6 verified that R1 does not understand to sit down, and R1's vision is poor. E6 stated, "I remember coming in that morning of 8/13/2015, (R1)'s temperature was elevated and (R1) had two black eyes, and (R1) was not acting himself. There was also some drainage from the back of (R1)'s head."

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S9999	Continued From page 7	S9999		

R1's discharge summary, dated 8/13/15 through 8/16/15 by Z1 (Primary Physician at local trauma hospital) documents: "R1 was admitted to the Neuro(ICU) Intensive Care Unit . R1 resides in a skilled nursing facility and has a history of ground level falls, most recently three days ago. R1 was found to have bilateral frontal contusions, bilateral acute on chronic subdural hematomas and traumatic intraventricular hemorrhage, likely from the fall. . . Time of death was recorded at 14:36 (2:36 PM)."

On 9/2/2015 at 9:42pm, E9 (Physician) stated, "I expect to be called with any change in resident's condition. I was not notified of (R1)'s bruising and change in condition on 8/8/15. I was notified of (R1)'s bruising of eyes and (R1)'s decline in mental status until on 8/13/2015 and gave orders to send to emergency room for evaluation and treatment."

R2's Physician's Order Sheet, dated 9/1/15 through 9/30/15, documents the following diagnosis: Alzheimer's, Agitation, Depression, Insomnia, Mood Disorder, and Vision Loss.
R2's (Facility Company)- Fall Risk Assessment, dated 7/14/15, documents that R2 is a high risk for falls, with a score of 20.
R2's Minimum Data Set, dated 7/14/15, documents R2's Brief Interview for Mental Status documents a score of zero. R2 is severely cognitively impaired.
R2's Incident Report Form, dated 7/14/15 at 5:00pm, documents that R2 stumbled and fell to the floor. R2 hit R2's head. R2 had a laceration to the back of R2's head. R2 was sent to the local Emergency Room for treatment. R2 received six staples to the the occipital laceration of R2's head.

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R2's care plan intervention for R2's 7/14/15 fall, was when R2 appears fatigued, attempt to lay R2 down, to allow R2 rest periods.
R2's care plan update, dated 7/15/15, documents to walk R2 with supervision and verbal cues, due to R2's unsteady gait.
R2's Incident Report Form, dated 8/1/15, documents that R2 was ambulating independently in the hallway. R2 fell backwards to the floor, hitting the back of R2's head on the floor. R2 received a laceration to the back of R2's head. R2 was sent to the local Emergency room for treatment. R2 returned to the facility with a pressure dressing to the macerated occipital area laceration.
R2's care plan update, dated 8/1/15, documents for a review of R2's medication.
R2's Incident Report Form, dated 8/4/15, documents at 8:30pm, R2 was ambulating independently and messing with R2's shirt. R2 lost her balance and R2 struck R2's head on the door frame. R2 was sent to the local Emergency Room for treatment. R2 received three staples to the back left side of R2's head.
R2's discharge note from the local Emergency Room, dated 8/4/15, documents for R2 to be on fall precautions.
On 9/3/15 at 12:30pm, E1/Administrator, verified that the facility does not have a fall precaution policy. E1 stated that the facility fall assessment is completed, and interventions for the Residents that are fall risks are put in place.
R2's care plan intervention, dated 8/4/15, documents for R2 to have a medication review with R2's Psychiatrist.
R2's Incident Report form,dated 8/29/15, documents that at 5:50pm, R2 was again ambulating independently in the hall. R2 was found on the floor, with R2's head against the wall. R2 was sent to the local Emergency Room

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S9999	Continued From page 9 for treatment of a laceration to the left side to R2's head. R2 received a 3.5 centimeter subcutaneous laceration to R2's left parietal area, requiring five staples. R2's care plan intervention, dated 8/29/15, documents to schedule pain medications for R2. On 9/2/15 at 9:20am, E5 Licensed Practical Nurse, verified that when a resident falls a Plan of Care Communication form is filled out. E5 also stated that with every fall a new care plan intervention is put into place immediately. On 9/2/15 at 1:38pm, E2 Director of Nursing, verified that all the staff should be following the facility's policies and procedures. E2 also stated that care given to the residents should be given according to the residents' individual care plans. (A)	S9999		

Attachment B
Imposed Plan of Correction

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: TOULAN REHAB & HEALTH CARE CENTER

DATE AND TYPE OF SURVEY: SEPTEMBER 3, 2015, INCIDENT INVESTIGATIONOF 7/3/2015-IL79780

300.610a)
300.1010h)
300.1210b)
300.1210d)3)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care

and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.*

THIS WILL BE ACCOMPLISHED BY THE FOLLOWING:

1. A committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding adequate nursing supervision and recognition of situations that would require Physician notification.

    A. Recognition of situations that could lead to resident injury and/or death.
    B. Appropriate reporting procedures for staff.
    C. Appropriate and thorough investigations and follow-ups of accidents, incidents, adequate supervision and physician notification.

D. The facility's responsibilities to prevent further potential abuse and/or neglect.
E. The facility taking appropriate corrective action when an alleged violation is verified.

2. The facility will conduct MANDATORY in-services for all staff within 30 days that addresses, at a minimum, the following:

   A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
   B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
   C. Documentation of these in-services will include the names of those attending, topics covered, location, day and time. This documentation will be maintained in the Administrator's office.

3. The following action will be taken to prevent re-occurrence:

   A. The above in-service education will be review with all staff on a regular basis.
   B. Supervisory staff will ensure that the State Regulations are followed.

4. The Administrator and Director of Nursing will monitor items 1 through 3 to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten days from receipt of the Imposed Plan of Correction.